

HEALTH REIMBURSEMENT ARRANGEMENT CLAIM FORM

HEALTH REIMBURSEMENT ARRANGEMENT CLAIM REQUEST FORM

To request reimbursement, please complete this form, include appropriate documentation and provide signatures where required. **All required fields applicable to your claim must be completed in order to process the claim.**

I certify that all listed expenses have not been reimbursed by any other source, nor will they be reimbursed by any other source including but not limited to my health insurance. In addition, I certify that these expenses were incurred for eligible members of my family or me.

Participant's Signature _____ Date

REQUIRED – CLAIM CANNOT BE PROCESSED WITHOUT YOUR SIGNATURE

NAME: LAST _____ FIRST _____ M.I. _____

SOCIAL SECURITY # _____ - _____ - _____ HOME TELEPHONE () _____

HOME ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

HEALTH REIMBURSEMENT ARRANGEMENT - (REQUIRED – COMPLETE ALL SECTIONS)

In order to receive reimbursement, copies of supporting documentation must be attached. Please include copies of an itemized bill from the provider listing exact dates of service (balance forward statements are not acceptable), service performed, charge and EIN# and an Explanation of Benefits (EOB) from your insurance company listing service dates, service performed and cost. Please retain a copy of this claim form and supporting documentation for your records, as we are unable to return original documents to you.

SERVICE DATE	DESCRIPTION	CLAIM TYPE	AMOUNT	PAY TO: MEMBER/PROVIDER
			\$	
			\$	
			\$	
			\$	
			\$	
			\$	
			\$	
			\$	
			\$	

Please mail the completed, signed form to the address below:



SIGNIFICA BENEFIT SERVICES, INC.
 P O BOX 7777, LANCASTER, PA 17604-7777
 PHONE 717-581-1300 • 1-800-433-3746
 FAX 717-581-8379 • www.significabenefits.com